STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155430	A. BUILDING _____ B. WING _____	03/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY CREEK AT ROCHESTER	340 E 18TH ST ROCHESTER, IN46975

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 03/21/11 Facility Number: 000326 Provider Number: 155430 AIM Number: 100290770 Surveyor: Phillip Komsiski, Life Safety Code Specialist At this Life Safety Code survey, Hickory Creek at Rochester was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code, (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery operated detectors in resident sleeping rooms. The facility has a capacity of 36 and had a census of 31 at	K0000	Attached for your review and anticipated approval you will find the completed Plan of Correction for the annual Life Safety Code Survey conducted on March 21, 2011 at Hickory Creek at Rochester, Rochester, IN. Please be advised that it is our intent to have this plan of correction also serve as our Allegation of Compliance. Compliance is effective on April 20, 2011. Should you have any questions regarding the attached Plan of Correction/Allegation of Compliance, please do not hesitate to contact me.Sincerely,Laura AlbrightAdministrator	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	the time of this survey. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0038 SS=F	Based on observation and interview, the facility failed to ensure the means of egress through 3 of 3 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice affects at least 45 % of residents as well as visitors. Findings include: Based on observations on 03/21/11 during the tour between 11:45 a.m. and 1:00 p.m. with the Maintenance Supervisor, all exit doors were magnetically locked and could be opened by entering a four digit code, but the code was not posted. Additionally, there was a sign posted above the keypad stating the code was available at the nurses' station. Based on interview with the Administrator	K0038	What corrective action will be done by the facility? It is the intent of this facility to have exit access arranged so that exits are readily accessible at all times. No residents were adversely affected by this practice. All residents have accessibility to exit facility without a clinical diagnosis requiring specialized security measures. A sign will be posted at each exit access that states "Code is month and year example for April code would be 0411*" The code will be changed each month by the maintenance director. How will the facility identify other residents having the potential to be affected by the same practice, and what corrective action will be taken? No residents were adversely affected by this practice. An in-service was provided to all staff on March 29, 2011 regarding exit access and new door code procedures. What measures will be put into place to ensure that this practice does not occur? Exit access will be monitored by the Maintenance Director or designee to ensure codes are properly changed according to posted sign on a monthly basis. Any issues or concerns will be corrected immediately.	04/20/2011

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	concurrent with the observations, it was acknowledged approximately forty five percent of the residents do not have a clinical diagnosis to be in a secure building. A resident without the clinical diagnosis requiring specialized security measures would have to ask a staff member to let them out if they did not know the code. 3.1-19(b)		How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The Maintenance Director or designee will report to the QA committee monthly any issues and concerns regarding exit access and follow up required.	

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K0050 SS=C	Based on record review and interview, the facility failed to conduct fire drills at unexpected times in 3 of 4 third shift fire drills for 2010. This deficient practice affects all residents in the facility as well as staff and visitors. Findings include: Based on review of Fire Drill records on 03/21/11 at 2:59 p.m. with the Maintenance Supervisor, three of four third shift fire drills were conducted between 5:15 a.m. and 5:45 a.m. Based on interview on 03/21/11 at 3:01 p.m. with the Maintenance Supervisor, it was acknowledged the fire drills done for the third shift of 2010 were not held randomly. 3.1-19(b) 3.1-51(c)	K0050	What corrective action will be done by the facility? It is the policy of this facility to hold fire drills at unexpected times under varying conditions, at least quarterly on each shift. A schedule has been created that only the Administrator and Maintenance Director are aware of to schedule out fire drills for the year at unexpected times and under varying conditions (attachment A). How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? No residents were adversely affected by this practice. What measures will be put into place to ensure that this practice does not occur? All staff was in-serviced on March 29, 2011 regarding fire drill procedures. The Maintenance Director was in-serviced on April 8, 2011 regarding fire drill procedures and holding them at unexpected times under varying conditions, at least quarterly on each shift. If further issues occur further education or discipline will occur. How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?	04/20/2011

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			The Maintenance Director or designee will monitor all fire drills on a monthly basis and bring any issues or concerns to QA committee for follow up.	

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K0062 SS=E	Based on observation and interview, the facility failed to replace 1 of 1 sprinkler heads in the Administrator's office which had paint on the glass tube. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect the 5 residents observed in the dining/lounge area next to the administrator's office as well as staff and visitors. Findings include: Based on observation on 03/21/11 at 11:25 a.m., one automatic sprinkler in the administrator's office had paint on the glass tube. Based on interview on 03/21/11 at 11:28 a.m. with the Maintenance Supervisor it was confirmed the sprinkler head located in the administrator's office had paint on the glass tube. 3.1-19(b)	K0062	What corrective action will be done by the facility? It is the policy of this facility to have automatic sprinkler systems that are continuously maintained in reliable operating condition and are inspected and tested periodically. The sprinkler head located in the Administrator's office was replaced with a new sprinkler head. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? No residents were adversely affected by this practice. The Maintenance Director or designee will check sprinkler heads monthly to ensure they are continuously maintained in reliable operating condition and any issues or concerns will be fixed immediately. What measures will be put into place to ensure that this practice does not occur? The Maintenance Director was in-serviced on April 8, 2011 regarding proper procedures on continuously maintaining sprinkler heads. The Maintenance Director or designee will check all sprinkler heads monthly for 6 months to ensure all sprinkler heads are maintained properly with no debris or paint on	04/20/2011

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			them. Issues and concerns will be fixed immediately. How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The Maintenance Director or designee will check all sprinkler heads monthly for six months to ensure all sprinkler heads are maintained properly. Maintenance Director or designee will bring any issues or concerns to the monthly QA committee for follow up.	

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K0130 SS=E	Based on observation and interview, the facility failed to ensure the location of 1 of 1 liquefied petroleum gas (LPG) containers was at least 25 feet away from a designated smoking area. LSC 8.4.3.1(3) requires the storage and handling of flammable liquids or gases to be in accordance with NFPA 58, 1998 Edition Liquefied Petroleum Gas Code. NFPA 58, Section 3-2.2.2 requires containers installed outside of buildings to be in accordance with Table 3-2.2.2. and Section 3-2.2.2(d) requires the distance measured in any direction from the point of discharge of a container pressure relief valve, the vent of a fixed maximum liquid level gauge on a container, or the installed location of the filling connection of a container to any exterior source of ignition, openings into direct-vent (sealed combustion system) appliances, or mechanical ventilation air intakes shall be in accordance with Table 3-2.2.2(d). Table 3-2.2.2(d) indicates the minimum distance between a LPG container with a water capacity of 501-2000 gallons and an exterior ignition source is 25 feet. This deficient practice could affect 10 residents located next to the smoking area as well	K0130	What corrective action will be done by the facility? It is the intent of this facility to the storage of flammable liquids or gases to be in accordance with NFPA 58 and that the distance measured in any direction from the point of discharge of a container is 25 feet from a designated smoking area. The designated smoking area was moved to an area to meet this standard on March 21, 2011. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be done? The designated smoking area was moved on March 21, 2011 to an area that is more than 25 feet from flammable liquids or gases. No residents were adversely affected by this practice. All staff was in-serviced on the location of the designated smoking area and that smoking will only be allowed in this designated area on March 29, 2011. What measures will be put into place to ensure that this practice does not occur? The Maintenance Director or designee will monitor the designated smoking area on a consistent basis to ensure visitors, staff, and residents adhere to smoking in designated areas only. Any issues or concerns	04/20/2011

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	as staff or visitors using the smoking area located behind the facility near the generator. Findings include: Based on observation on 03/21/11 at 12:45 p.m. with the Maintenance Supervisor, the LPG container with a capacity of seven hundred and fifty gallons was 18 feet from the designated smoking area. Based on interview on 03/21/11 at 12:50 p.m. the Maintenance Supervisor acknowledged after making a measurement, the location of the smoking area and the distance from the LPG container was eighteen feet. 3.1-19(b)		will be rectified immediately. How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The Maintenance Director or designee will report to the QA committee monthly any issues or concerns with the designated smoking area or visitors, staff, or residents smoking within 25 feet of flammable liquids or gases.	

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K0147 SS=D	Based on observation and interview, the facility failed to ensure extension cords including powerstrips and nonfused multiplug adapters were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice would affect 2 residents in the room as well as visitors and staff. Findings include: Based on observation on 03/21/11 at 12:06 pm. with the Maintenance Supervisor, a nebulizer servicing the resident in room number one plugged into a powerstrip at the foot of the resident's bed and not directly into a wall outlet. Based on interview on 03/21/11 at 12:08 p.m. it was acknowledged by the Maintenance Supervisor, the facility is aware all medical equipment must be plugged directly into a wall outlet and not a powerstrip. 3.1-19(b)	K0147	What corrective action will be done by the facility? It is the intent of this facility to ensure extension cords including power strips and non-fused multiplug adapters are not used as a substitute for fixed wiring and that all medical equipment is plugged directly into a wall outlet and not a power strip. The medical device was unplugged from the power strip and plugged directly into the wall outlet on March 21, 2011. All other rooms were toured to ensure no medical devices were plugged into power strips. How will the facility identify other residents having the potential to be affected by this practice and what corrective action will be done? All staff was in-serviced on March 29, 2011 regarding not plugging medical devices into power strips. The Maintenance Director or designee will monitor resident rooms to ensure medical devices are not plugged into power strips on a monthly basis. If a medical device is found to be plugged into a power strip staff will be disciplined appropriately. No residents were affected by this practice. What measures will be put into place to ensure that this practice does not recur. The Maintenance Director or	04/20/2011

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			designee will monitor resident rooms to ensure medical devices are not plugged into power strips on a monthly basis. This will be added to the monthly maintenance rounds sheet for room checks. How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? This will be added to the monthly maintenance rounds sheet for room checks and any issues or concerns will be reported to the QA committee monthly for follow up.	